TABLE 19. PERCENT OF PHYSICIANS CERTIFIED IN THEIR SPECIALTY, 1983

Specialty	Percent Certified
Generalists a/	
Family practice	60
Internal medicine	47
Pediatrics	54
Nonsurgical Specialists	
Allergy	25
Cardiology	75
Dermatology	73
Gastroenterology	78
Nephrology	N.A.
Neurology	53
Physical medicine	51
Pulmonary	73
Psychiatry	46
Surgical Specialists	
General surgery	50
Otolaryngology	68
Neurosurgery	60
Gynecology	58
Ophthalmology	71
Orthopedic surgery	67
Plastic surgery	61
Colon and rectal surgery	58
Thoracic surgery	69
Urology	71
Radiology	86
Anesthesiology	44
Pathology	71
All Physicians Claiming a Specialty	56

SOURCE: Congressional Budget Office from data in Mary Ann Eiler, "Physician Characteristics and Distribution in the United States" (American Medical Association, Chicago, Illinois, 1984).

NOTE: N.A. = not available.

a. General practice is not included in this table, since there is no specialty certification for general practitioners.

complex than services obtained from a generalist during a visit of the same type, since surveys indicate that specialists often provide primary care. 12/

One option that could help to dissuade Medicare enrollees from using specialists when their extra skills were not required would be to pay specialty rates only for patients who were referred to a specialist by a primary care physician. Without a referral, Medicare could reimburse only at the rate allowed for generalists. 13/ As proof, specialists could be required to attach referral cards from referring physicians to their insurance claims. Primary care physicians might include not only general and family practitioners, but also general internists, pediatricians, and perhaps gynecologists. Physicians practicing in specialties excluded from the definition of primary care would likely object to this approach, however, since it would reduce demand for their services. Further, Medicare enrollees who have used specialists as their primary care physicians would either have to change physicians or face higher out-of-pocket costs for care.

Another option would be to eliminate specialty differentials, and to define visits by time. There is some evidence to indicate that Medicare's payment rates per unit of time are already similar across physician specialties. 14/ Although payment per visit is higher for internists and specialists than for general and family practitioners, visits of a given type also tend to be longer with internists and specialists. Consequently, the financial effects on physicians of eliminating specialty differentials for visits could be very small if payment for visits were time-based. On the other hand, if specialty differentials were eliminated and current visit codes were retained, general and family practitioners might be paid more per hour than internists and specialists, because visits with general and family practitioners are typically shorter. (See Appendix B for estimates of the effects of alternative choices concerning specialty differentials.)

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12. Robert Mendenhall and others, "The Relative Complexity of Primary Care Provided by Medical Specialists," *Medical Care*, vol. 22, no. 11 (November 1984), pp. 987-1001.

13. The practice in some Canadian provinces is even more restrictive, in that no insurance reimbursement is made for specialists' services without proof of a referral from a primary care physician.

14. See Mitchell and others, "Alternative Methods for Describing Physician Services Performed and Billed," pp. 90-91.

The Monetary Multipliers

A relative value scale would become a fee schedule by setting a value for the monetary multiplier (or multipliers) to be applied to each item in the scale. Multipliers could be used to account for differences in costs both by location and over time. Selective adjustments to the multipliers might be made for some localities or for certain specialties where there was evidence of a shortage of physicians willing to treat Medicare enrollees at the approved rates. Further, the multipliers could be used as part of an effort to control use of services. (See "Quality and Volume Controls," below, for discussion of this last point.)

Multipliers might be set in a number of ways: unilaterally by Medicare, after negotiations with some designated physicians' group, or as the result of bidding by physicians. The discussion here is limited to ways that unilateral decisions could be made by Medicare, although informal discussions or negotiation with physician groups would doubtless be a part of that process, just as discussions with hospital associations are a part of the rate-setting process under the prospective payment system.

Unilateral decisions by Medicare would give Medicare greater control over costs than would the alternative approaches and would be straightforward to implement. In particular, multipliers that were set unilaterally could be scaled to be budget-neutral, or to increase or reduce Medicare costs by any specified amount (at least until altered by changes in the use of services initiated by physicians or their patients). Under the negotiating or bidding approaches, the effect on aggregate Medicare costs would be an outcome of the process. 15/

Formal negotiations on physicians' payment rates could be difficult for Medicare to implement, both because Medicare is only one of many payers, and because there is no physicians' group that would clearly be the appropriate one with which to negotiate. Further, a bargaining framework would not be necessary to permit physicians to express their dissatisfaction with Medicare's payment rates; dissatisfaction could be assessed informally based on the proportion of physicians who signed participating agreements and the assignment rates for nonparticipating physicians. This contrasts with the situation in other countries where no significant market for the services of physicians exists outside the public insurance system, so that formal negotiations are important as the only mechanism--short of refusing to practice medicine--by which physicians can voice their discontent.

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15. Budget-neutrality is assumed for the options discussed in Appendix B solely for analytical purposes, in order to identify the effects of changes in specialty or location differentials without the complication of a change in aggregate payment amounts.

Bidding systems are untried and would require further study or demonstration before they could be used to set Medicare's maximum payment rates. A variant might be combined with a fee schedule set by Medicare, however, to foster competition among physicians willing to accept payments below the fee schedule amounts. Physicians could submit bids each year that would show the minimum multiplier--and resulting fee schedule--that each physician would be willing to accept as payment in full as a participating physician. If Medicare publicized each physician's multiplier as a part of the information it provided about participating physicians, enrollees would have a convenient way to locate low-cost physicians, thereby not only avoiding balance-billing but also reducing their 20 percent coinsurance costs.

Differences by Location. An argument might be made for eliminating all differences by location in Medicare's payment rates for SMI services, because SMI premiums do not vary by location. If location differences were eliminated, however, the adverse effects on physicians and their Medicare patients would be substantial in high-cost areas such as New York, California, and Alaska. Because physicians' living and practice costs vary by region and (to a lesser extent) between urban and rural areas within regions, some differences in payment rates by location would probably be desirable to ensure adequate access for Medicare enrollees in all parts of the country. (SMI premiums, however, might be adjusted by location to reflect cost differences.)

One option would be to set multipliers for each payment locality (or some larger geographic area such as the state) so that aggregate Medicare payments by location would be unchanged by substitution of a fee schedule for CPR rates at the time of implementation (budget-neutral), although the allocation of payments among physicians would likely be different. This approach would perpetuate current differences in payment levels by location, however, even though they appear to be only partially related to costs.

An alternative would be to set location-specific multipliers based on an index of costs. These multipliers could be set to be budget-neutral nationwide, if desired, but would only coincidentally be budget-neutral by location. Location-specific multipliers could be designed to adjust Medicare's payment rates to reflect local differences in physicians' costs (just as DRG rates are adjusted for local wage costs under the prospective payment system, using the PPS wage index). Although no clearly appropriate location-specific index of costs exists at this time, the Medicare Economic Index provides a framework for developing one.

An appropriate index, or adjuster, would show how much more or less, relative to the national average, it would cost physicians locally to pay for a

representative package of goods and services normally required to practice. While some physicians in a locality might spend more or less than the amount implied by the adjuster, it would be unnecessary to adjust payment rates to reflect cost differences that resulted from physicians' different preferences--for more luxurious office space, for example. It might be desirable, however, to recognize that physicians in rural areas probably practice in an environment in which their ability to use practice resources efficiently is more limited than it is in urban areas, with the result that their total practice costs could be closer to those of urban practices than per unit costs for personnel and office space would indicate (see Chapter II for further discussion of this).

The weights attached to each expense category in the MEI implicitly define a representative package of resources used by physicians, once a per unit cost nationwide for each expense item is estimated. About 40 percent of gross revenues to physicians goes for practice expenses: 18.8 percent pays for nonphysician office personnel; 9.2 percent for office space; 4.0 percent for malpractice insurance; 3.6 percent for drugs and other office supplies; 2.8 percent for transportation; and 1.6 percent for miscellaneous expenses. The remaining 60 percent of gross revenues represents net physician income. 16/ Hence, one index to adjust physicians' payment rates could be obtained by combining:

- The ratio of local to national hourly costs for nonphysician personnel, with a weight of 0.188;
- The ratio of local to national commercial rental costs per square foot, with a weight of 0.092;
- The ratio of local to national malpractice insurance premium costs (for a given type and amount of coverage), with a weight of 0.040; 17/

16. These are the weights for the MEI used to determine increases in MEI-adjusted prevailing fees effective May 1, 1986, as announced by the Health Care Financing Administration in the *Federal Register*, vol. 50, no. 189 (September 30, 1985), pp. 39941-39946. The weights are revised each year, based on special studies conducted by HCFA.

17. The malpractice insurance premium in the adjuster should reflect the average cost for some standardized coverage, with the average calculated for a given mix of physician specialties--perhaps the national mix of specialties treating Medicare patients. It would not be appropriate to vary the location-specific adjuster based on differences by location in the mix of specialties represented, even though malpractice costs differ by specialty. Such costs should, instead, be reflected in the relative value scale.

- The ratio of local to national costs for a representative set of drugs and pharmaceutical supplies, with a weight of 0.036;
- The ratio of local to national costs for given transportation services, with a weight of 0.028;
- The ratio of local to national costs for miscellaneous expenses (using an all-items price index, for example), with a weight of 0.016; and
- The ratio of local to national living costs or earnings per capita, with a weight of 0.600.

In the last item, living costs would be used if the goal was to adjust payment rates to represent the same real net income per service for physicians across localities. Earnings would be used if the goal was to adjust payment rates to reflect the general level of earnings in the locality. Or, the ratio in the last item could be set to one if it was decided that Medicare's payment rates should not contribute to variation in physicians' net incomes by locality.

The difficulty in constructing this index is that information by locality is very limited for all of the components. The Consumer Price Index (CPI) provides some local cost information for overall living costs, for residential (but not commercial) rent, and for transportation. This information is available, however, only for 28 metropolitan areas or for four classes of urban areas (defined by population size) in each of the four census regions. It seems likely that payment rates would need to be adjusted at a finer level--by state, for example--because taxes, insurance regulations, and legal systems vary by state. 18/ It might be desirable to set payment rates separately for metropolitan and nonmetropolitan areas within each state, although the need for this is less clear, for reasons discussed above.

Ideally, the elements in the index would be based on data that are regularly collected by such organizations as the Bureau of Labor Statistics (BLS) or the Bureau of the Census, rather than on data from special surveys, which are costly to field and not reliably funded. The original PPS wage

18. The jurisdictions of current Medicare carriers are statewide in most instances. Seven states have more than one carrier, but in four instances this occurs only because there is one carrier responsible for a single metropolitan area that crosses state boundaries. Hence, the carrier for Washington, D.C., also serves suburban counties in Maryland and Virginia. The carrier for Kansas City has a jurisdiction that is partly in Kansas and partly in Missouri. The states of California and Minnesota are each served by two carriers, while New York is served by three carriers.

index used area-level data on wages that are regularly collected by BLS, for example. That index was faulted, however, because the BLS data do not distinguish between part-time and full-time employment. Consequently, the Health Care Financing Administration developed a new index (to be implemented May 1, 1986) based on a survey of hospitals that treat Medicare patients. 19/ No provisions have yet been made for updating the new index.

The PPS wage index might serve adequately for two components of the adjuster--physicians' net income and wage costs for nonphysician personnel--that account for nearly 80 percent of physicians' costs. 20/ It probably would not account well for differences in the other 20 percent of costs--for office space, supplies, and malpractice insurance. For area-level data on commercial office rents and malpractice costs, periodic surveys would likely be necessary. 21/ The other components of costs for physicians are unlikely to vary significantly by location, so that a ratio of one might be used in the index for each.

Adjustment of pay rates using only an index of costs would ignore supply and demand considerations, though, so that rates in some areas might not be high enough to ensure adequate access for Medicare enrollees. As a result, selective adjustments unrelated to costs might be necessary in some locations.

Annual Increases. Although differences in payment rates by location might be adjusted periodically as new location-specific cost information was obtained, general increases in payment rates might be warranted more frequently in response to general inflation. For example, annual updates of payment rates might be based on increases in the Medicare Economic Index. Alternatively, annual increases might be based on increases in the GNP

19. There is a problem even with the new PPS wage index, though. Hospitals were generally unable to eliminate hours worked and wages and salaries paid to hospital residents and other hospital-based physicians, with the result that the estimates of hourly wage costs for nonphysician hospital personnel include varying amounts for physicians as well. The PPS wage index therefore is probably an overestimate of hourly wage costs for nonphysician hospital personnel, particularly in areas with teaching hospitals.

20. Using the PPS wage index, a value can be assigned to each county in the state. These county-level index values can be combined to obtain a single value statewide, or separate values for all metropolitan and nonmetropolitan areas in the state, by calculating a weighted average over all the counties in the area of interest. The weights could be based on the number of physicians treating Medicare patients or on the total of Medicare reimbursements in each county.

21. The Health Care Financing Administration currently conducts an annual survey of malpractice insurance costs for use in reweighting the MEI, but this survey might have to be expanded to yield reliable information by state. The only information currently available on commercial rents by location is from various real estate trade organizations.

deflator--a widely used indicator of economywide inflation--if the Congress wished to ensure that fee increases for physicians did not diverge from general inflation. There has been very little difference between increases in the MEI and the GNP deflator since 1975 when the MEI was first reported, however.

Annual increases in payment rates based on an index such as the MEI or the GNP deflator might be modified, though, if Medicare's payment rates did not keep pace with those of other payers. If Medicare's payment rates were generous relative to other payers, for example, Medicare costs could be reduced through lower annual increases without adversely affecting enrollees' access to care. On the other hand, if Medicare's payment rates were significantly below those of other payers, rate increases might have to be higher than would be justified by the index in order to maintain adequate access to care for enrollees.

Making the Transition from CPR to Fee Schedule Rates

Immediate substitution of a fee schedule for the CPR system could be disruptive, since Medicare payments to one-quarter or more of physician practices would fall by at least 10 percent, even if aggregate payments to physicians were unchanged (see Appendix B). If the Congress wished to smooth the transition by phasing in fee schedule rates, this could be done in at least two ways: the payment mechanisms could be blended for a transition period, or a "hold-harmless" provision for physicians could be implemented.

Blended Payment Rates. Fee schedule rates could be phased in using a system similar to the one used to introduce the prospective payment system; that is, payment for each service could be a blend of CPR and fee schedule rates, with the blend increasingly weighted toward the fee schedule until use of CPR rates was eliminated. For example, payment rates could be determined as follows:

Year	Payment Rates
1	75% of CPR + 25% of Fee Schedule Amounts
2	50% of CPR + 50% of Fee Schedule Amounts
3	25% of CPR + 75% of Fee Schedule Amounts
4	100% of Fee Schedule Amounts

This would mean less disruption for physicians but more complicated administration for carriers. Further, to the extent that fee schedule rates would induce desirable behavioral changes by physicians, these effects would occur more slowly than if the fee schedule were fully implemented without a transition period.

Hold-Harmless Provisions. Alternatively, physicians could be assured that there would be no reduction in their payment rates from the preceding year's levels as a result of implementing a fee schedule. Physicians could be paid fee schedule rates for all services except those for which fee schedule rates would be below Medicare's approved amounts for the previous year. In such instances, payment rates could be frozen at the previous year's approved amounts until fee schedule rates had increased to match them. This approach, however, would cost more than immediate implementation of fee schedule rates and could delay full implementation of the fee schedule for years. If that were a concern, the Congress could attach a "sunset" clause to the hold-harmless provision to limit its duration.

A less costly alternative would not only freeze CPR rates that were above fee schedule rates, but also delay increases to fee schedule rates for physicians whose CPR rates would have been lower. That is, rates for physicians who would receive higher payment under a fee schedule than under continuation of the CPR system could be increased to match the fee schedule gradually, over several years, rather than immediately in the year the fee schedule was implemented.

ASSIGNMENT AND ACCESS TO CARE

Medicare's potential for constraining fees and total costs for physicians' services is limited by concern about enrollees' access to care. Enrollees' access could be reduced in either of two ways: physicians could refuse to treat them at all, in favor of other population groups; or physicians could accept them as patients but refuse to accept assignment, so that enrollees would be liable for balance-billing. 22/ So long as Medicare's fees covered costs, however, it seems unlikely that many physicians would refuse to accept Medicare patients, since the number of physicians per capita is increasing and the Medicare population is a large and growing share of total patient load. Although access might be inadequate in certain localities or among certain specialties, this problem could be addressed by making selective increases in fee schedule multipliers. Moreover, widespread refusal by physicians to accept assignment is unlikely because of heightened competition for patients as a result of the growing supply of physicians. 23/

22. Nonparticipating physicians who treat Medicare patients currently are free to make assignment decisions on a claim-by-claim basis, while participating physicians agree on a year-to-year basis to accept assignment for all their Medicare patients.

23. Alma McMillan, James Lubitz, and Marilyn Newton, "Trends in Physician Assignment Rates for Medicare Services, 1968-1985," *Health Care Financing Review*, vol. 7, no. 2 (Winter 1985).

Where assignment rates did fall, payment rates could be increased, since the decision to accept assignment is clearly affected by the relationship between Medicare's payment rates and physicians' actual charges.

Medicare's efforts to control costs would be less constrained by concern about enrollees' access if assignment rates could be increased by mechanisms other than increasing payment rates. Costs might rise somewhat with increased assignment, however, since some unassigned claims are not submitted by enrollees now, even though reimbursement would be made if they were submitted.

Two options that might further increase assignment rates are discussed here: one would increase incentives for assignment by providing participating physicians with one-stop billing, relieving them of the need to bill patients at all; the second option would make assignment mandatory on all Medicare claims. A third option that would require nonparticipating physicians to make an "all-or-nothing" choice on assignment--that is, either accept all Medicare claims on assignment for a designated period, or accept none of them--is not discussed, because studies show that the aggregate assignment rate on Medicare claims would fall under this approach. According to these studies, most physicians who currently accept assignment on a claim-by-claim basis would lose more through elimination of balance-billing on claims they currently refuse to assign than they would from loss of patients they currently treat on an assigned basis. 24/

Provide One-Stop Billing for Participating Physicians. One important factor that affects physicians' assignment decisions is the ease of collecting payment on assigned claims. Relevant considerations include the time the carrier takes to pay claims, whether the carrier is also a major medigap insurer, and whether medigap policies cover deductible amounts as well as coinsurance amounts. 25/ Billing is simplified when the carrier is also the medigap insurer and medigap covers deductible amounts, since physicians who accept assignment need submit claims to only one carrier for payment. When the carrier is not the medigap insurer, physicians must also bill patients or a second carrier to collect deductible and coinsurance amounts even on assigned claims. Hence, physicians who are confident their patients will pay may choose to eliminate the need for double-billing by refusing assignment.

24. See Janet B. Mitchell and Jerry Cromwell, "Impact of an All-or-Nothing Assignment Requirement Under Medicare," *Health Care Financing Review*, vol. 4, no. 4 (Summer 1983), pp. 59-78; and David Juba and others, "Physician Behavior Under an All or None Assignment Policy," Working Paper 1306-02-10 (Urban Institute, Washington, D.C., December 1984).

25. McMillan, Lubitz, and Newton, "Trends in Physician Assignment Rates for Medicare Services, 1968-1985."

Medicare carriers could be instructed to pay all of the allowed fee to participating physicians, thereby relieving such physicians of the need to bill their patients for deductible and coinsurance amounts. Having carriers bill patients or medigap carriers for copayment amounts would increase physicians' incentives to participate (especially if coupled with faster claims processing), but would transfer the costs of bad debt from physicians to the Medicare program and would increase administrative costs for carriers. Estimated copayment amounts for physicians' services under Medicare in 1985 totaled $6.1 billion. While this amount means that the maximum potential costs to Medicare for bad debt would be substantial, most copayments would actually be paid by medigap policies or Medicaid. If there were difficulty in collecting remaining amounts owed by enrollees, some provision might be made to collect past-due amounts by deducting them from Social Security checks, just as SMI premium payments are currently collected. This might substantially increase Social Security's administrative costs, though, because it would be far more difficult to use the system to collect past-due payments on an irregular basis than it is to collect fixed monthly premium amounts.

Make Assignment Mandatory Under Medicare. If assignment were mandatory, Medicare enrollees who see physicians who do not accept assignment would be responsible for all of those physicians' charges. Medicare would pay no part of charges on unassigned claims. The major advantage of this approach is that it would almost certainly increase the share of physicians accepting assignment for all their Medicare patients (nearly 30 percent of physicians who treat Medicare patients currently participate). One survey of physicians indicated that about 75 percent of self-employed physicians would accept Medicare patients if assignment was mandatory. 26/

A mandatory assignment requirement has a number of disadvantages, however. It would eliminate the option physicians now have of collecting their usual charge from patients who are able to pay, while accepting less from other patients. The patients of those physicians who refused assignment either would be liable for all of their physicians' charges or would have to find new physicians. Access to physicians could be reduced, particularly to prestigious physicians who are so much in demand that they can afford to lose their Medicare patients, and to specialists who are not heavily dependent on the Medicare population, such as gynecologists and pediatricians. Further, some physicians who agreed to the mandatory requirement could encounter a sharp reduction in receipts from Medicare patients, creating incentives to provide them with second-class care. The

26. CBO tabulations from the Health Care Financing Administration's 1984 Physicians' Practice Costs and Income Survey.

significance of these effects, though, would depend critically on how generous Medicare's payment rates were relative to those of other payers. Pressures from both Medicare enrollees and physicians to increase Medicare's rates might therefore be stronger than they are now, because balance-billing would no longer provide an escape from Medicare's constraints.

QUALITY AND VOLUME CONTROLS

There would be no concerns about quality of care under a fee schedule that do not already exist under the CPR system. In a fee-for-service system, quality is a problem primarily to the extent that providing unnecessary services is both risky and costly for patients. Hence, controls for excessive volume of services are also quality controls. Underprovision of appropriate care would not have to be monitored unless service packages were developed.

The volume of services in a fee-for-service system could be controlled in ways that are not now being used by Medicare: volume-related adjustments to the monetary multipliers used to update payment rates could control spending in the aggregate, and systematic monitoring of physicians' practice profiles could help to prevent individual physicians from gaining at the expense of the group. These methods have been used with success in other countries, as discussed in Appendix A.

Total approved charges per enrollee might be constrained to increase each year by no more than physicians' cost increases, as measured by the Medicare Economic Index, for example. If volume per enrollee were constant, increasing the monetary multiplier in each region by growth in the MEI would accomplish this result. If volume increased, however, total approved charges per enrollee would increase by more than costs. In this case, the multiplier adjustment in the following year could be reduced from the increase justified by the MEI for that year, to offset the volume increases of the preceding year. Or adjustments to payment rates might be made in the same year, based on projections of spending.

The same mechanism could be used even if some increase in volume per enrollee was thought to be desirable, to account for aging of the Medicare population and medical advances, for example. Approved charges per enrollee could be permitted to increase by growth in costs plus an appropriate allowance for these factors, before triggering downward adjustment of payment rates. Determining the appropriate allowance for factors such as aging and technology could be difficult, however. This is especially so for

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medical advances, since they could either increase or reduce the variety and costs of services that could be of benefit to enrollees. One, essentially arbitrary, option would be to allow approved charges per enrollee to grow each year by growth in GNP, so that some increase in volume of services per enrollee would be permitted so long as Medicare's payment rates increased less rapidly than GNP. Alternatively, the growth in total approved charges for physicians' services could be limited to growth in GNP. Unless medical price increases were lower than the economywide average price increase, however, this limit would result in a decline in the volume of services per enrollee if the Medicare population grew more rapidly than real GNP.

If adjustments to payment rates were used to offset aggregate volume increases, most physicians would want carriers to monitor their peers for excessive billing, using claims data to construct physician profiles, because otherwise some physicians could gain at the expense of the group by increasing their billings by more than average. Sanctions against physicians whose practice patterns or billings were found to be unwarranted could include recoupment of payments, expulsion from the Medicare program, or prosecution for fraud, depending on the circumstances. The profiles would be used only to identify claims that merited further investigation, so that physicians would have an opportunity to justify their service patterns before carriers would decide whether sanctions were justified. Physicians who treated unusually severe cases thus would not be penalized. Analysts in countries that use this method of volume control believe that physicians' awareness that practice profiles are examined is generally sufficient in itself to limit overprovision of services.

The use of physician profiles has an additional advantage in that it could help to reduce the wide variation in treatment patterns that exists currently, apparently stemming from lack of information or consensus about what constitutes appropriate care in some cases. Under some conditions, physicians are quick to adjust their practice patterns when made aware that their practices diverge from the norm. 27/

Savings from implementing a fee schedule to replace the CPR system could be substantial if coupled with controls on use of services, including a cap on spending. If a fee schedule for physicians' services were implemented on January 1, 1988, based on average amounts allowed for each service during the previous year, with annual increases in payment rates set each year thereafter by the MEI, cumulative estimated savings from current law would total $1.2 billion through 1991 (see Table 20). With the addition of a spending cap on charges per enrollee set by growth in the MEI,

27. See *Health Affairs*, vol. 3, no. 2 (Summer 1984). The entire issue is devoted to analysis of practice variations across localities.

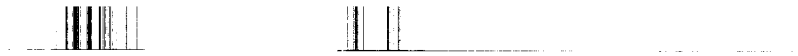
TABLE 20. FEDERAL SAVINGS FROM IMPLEMENTATION OF A MEDICARE FEE SCHEDULE FOR PHYSICIANS' SERVICES, FISCAL YEARS 1987-1991 (In millions of dollars)

Type of Fee Schedule	1987	1988	1989	1990	1991	Cumulative Five-Year Savings
Rates Increased Each Calendar Year by the MEI and:						
No Cap on Spending	--	90	220	360	490	1,160
Cap on Growth in Charges Per Enrollee Set by Growth in MEI	--	320	970	1,780	2,670	5,740
Cap on Growth in Charges Per Enrollee Set by Growth in GNP	--	90	240	440	670	1,440
Cap on Growth in Total Charges Set by Growth in GNP	--	300	810	1,470	2,230	4,810

SOURCE: Congressional Budget Office.

NOTES: MEI = Medicare Economic Index; GNP = gross national product. These estimates assume that participating and nonparticipating physicians would be treated alike under the fee schedule.

cumulative savings through 1991 would be $5.7 billion, but this option would permit no increase in the volume of services per enrollee. If increases in charges per enrollee were limited to the rate of growth in GNP, cumulative savings would be $1.4 billion through 1991. This option would permit volume increases nearly equal to those projected to occur in the absence of a spending cap. Finally, if growth in total charges were limited by growth in GNP, cumulative savings would be $4.8 billion through 1991. This option would permit some increase in services per enrollee over the projection period, and would ensure that Medicare's spending for physicians' services would not grow as a percentage of GNP. This option could result in reduced services per enrollee in later years, though, when the aged population begins to swell because of the baby boom cohort.



CHAPTER V

CASE-BASED PAYMENT SYSTEMS

More fundamental changes in Medicare's payment methods for physicians might be made in the long run by basing payment on comprehensive service packages, thereby altering the incentives for expanding the volume of services that are inherent in fee-for-service payment methods. One option would be case-based packages that would include all services related to a given case, condition, or episode of care.

Under a case-based payment system, a fixed payment would be made for all condition-related medical services during a defined episode of care, regardless of the actual services provided. Physicians would have incentives to curtail unnecessary services within the case package because their costs would come out of the fixed case payment; ancillary services, including the services of other physicians, would no longer be free for the primary physicians. One disadvantage of such a system is that physicians might in some cases forgo medically necessary care as well, although medical ethics and concern about malpractice suits would work against this. In addition, physicians would have incentives to shift services outside the package to increase reimbursement.

Further research on alternative ways to define episodes of care, on criteria for classifying patients, and on implementation methods would seem advisable, because there is virtually no experience with comprehensive case-based payment methods for physicians' services. 1/ It is uncertain how to define cases appropriately for physicians' care, how to distribute payments

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1. Current packaging of pre- and postoperative visits with the charge for surgery is only a very limited form of a case-based package, since charges for laboratory tests, x-rays, and the services of other physicians are billed separately. In the early 1970s, an experimental case-based payment method for inpatient services was implemented by Pennsylvania Blue Shield, but here, too, the payment package covered only the primary physician's services. See report by Gene A. Markel, "Hospital Utilization Effects of Case Reimbursement for Medical Care," pp. 95-99 in Jon R. Gabel and others, eds., *Physicians and Financial Incentives* (Department of Health and Human Services, HCFA Publication No. 03067, December 1980).

for a given episode among the various physicians on the case, how physicians would respond to the incentives created, and how enrollees might be affected.

In principle, case-based payment categories could be defined for some or all inpatient services and for some or all ambulatory services. But in practical terms, a case-based payment system would probably have to be limited to inpatient services because of the difficulty of defining an episode of care for most ambulatory conditions. Unless ambulatory cases were defined to cover all services provided during a specified period of time (similar to a capitation payment), there would likely be too much ambiguity about which services were to be included in the case payment and which were outside the condition and therefore eligible for additional reimbursement. 2/

Two case-based payment methods are discussed in this chapter: one that would cover all inpatient physicians' services for all episodes of care; and one that would cover all inpatient episodes but only for services of certain hospital-based physicians.

PACKAGING ALL PHYSICIANS' SERVICES FOR ALL INPATIENT EPISODES

One option under discussion is to pay for all physicians' inpatient services on a case basis, similar to Medicare's payment for hospital services under the prospective payment system, in which diagnosis-related groups (DRGs) are used to classify patients for payment purposes. 3/ Physicians' services could be packaged together with hospital services, and a single payment made for each case--either to the hospital or to a joint venture established by the hospital and its medical staff. Alternatively, a separate payment for physicians' services could be made either to individual primary physicians or to the hospital medical staff as a group.

Paying physicians by DRG or some other grouping system could give physicians strong financial incentives to forgo services with little or no

2. See Chapter 8 in Janet B. Mitchell and others, "Alternative Methods for Describing Physician Services Performed and Billed," Report No. 84-4 (Health Economics Research, Inc., Chestnut Hill, Massachusetts, May 1984).

3. See Janet B. Mitchell and others, "Creating DRG-Based Physician Reimbursement Schemes: A Conceptual and Empirical Analysis, Year 1 Report" (Center for Health Economics Research, Chestnut Hill, Massachusetts, October 1984), for a detailed discussion of this approach.